SCHOOL WELLNESS PROGRAM POLICY & PROCEDURE ESSENTIAL ELEMENTS: NURSING DOCUMENTATION

THIS DOCUMENT IS TO BE USED AS A GUIDANCE TOOL IN DEVELOPING CONSENT POLICIES AND PROCEDURES FOR SCHOOL WELLNESS PROGRAMS.

Definition: Documentation provides evidence that care is meeting quality and safety standards as well as providing the legal record for health services.

Purpose: The purpose of the documentation policy is to ensure nursing documentation is accurate, comprehensive, maintains continuity of care and care coordination, tracks client outcomes and reflects current standards of nursing practice.

Procedures:

- Ensure systems are in place to safeguard the privacy, security, access, integrity/backup, maintenance, retention, destruction, and appropriate sharing (verbal, fax, email, electronic) of students' health, mental health and other school records contained in the health office.
- Include assessment (subjective and objective data) and identification of a nursing diagnosis, plan/implementation of the plan, follow-up, and outcome/disposition in nursing documentation. Document consultations with the medical director, PCP, specialty care, mental health, school staff and parent/guardians.
- Document discussion of informed consent and any refusal or deferral of treatment.
- Complete record as soon as possible after an event occurred. Include timelines consistent with fiduciary policies and procedures.
- Ensure notes are clear with date and time of entry.

References

Bergren, M.D. (2005). Data integrity: Backup. The Journal of School Nursing, 21(1), 60-62. doi: 10.1177/10598405050210041001

Resha, C.A., Taliferro, V.L. &Gilsbach, E.D. (2017). *Legal Resource for School Health Services.* Nashville, TN: SchoolNurse.com.